Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

IPC OF TEXAS
4605 LANKERSHIM BLVD SUITE 421
NORTH HOLLYWOOD CA 91602

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-0295-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At the time of service the patient provided incorrect insurance. We sent claim to patient as it was listed as Self Pay on hospital face sheet. Liberty Mutual denied the claim for untimely filing. It is our position that the claim was not billed within the timely statute because the information provided to us was incorrect."

Amount in Dispute: $1,387.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed charges for date(s) of service 03/21/10 through 03/27/10 for physician visits were denied as not timely billed. Our records indicate that the HCFA 1500 was not received by Liberty Mutual until 09/20/10 which, well exceeds the 95 day time period for bill submission. Additionally, the provider shows 09/13/10 s the bill date on the HCFA 1500 (box 31), copy of HCFA enclosed. We do not feel that reimbursement is warranted for 03/21/10 to 03/27/10."

Response Submitted by: Liberty Mutual, 303 Jessee Jewell Parkway, P. O. Box 4223, Gainesville, GA 30503

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2010 Through March 27, 2010	99223, 99232, 99233, 99239	$1,387.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated November 17, 2010
   - F286 – DATE (S) OF SERVICE EXCEED (95) DAY TIME PERIOD FOR SUBMISSION PER RULE 408.027 AND BULLETIN NO. B-0037-05A. (F286)
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are March 21, 2010 through March 27, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 27, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 20, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.